FOOTHILL ENT CARE SPECIALISTS, INC.
LEWIT WORRELL, M.D.
Adult & Pediatric: Ears, Nose, Throat
Head & Neck, Facial Plastic Surgery

Patient Information Sheet

Patient:

Name(Last,First,MI)_____DOB(mm/dd/yyyy)_____Age_____

SS#_____-_____-_____Drivers License#_____ Occupation_____

Address_____City_____

State_____Zip code_____ Sex_____Marital Status: S / M / D / Sep / Widow / Civil Union / Other

Home Tele#:( )_____-_____Cell# ( )_____-_____Work#( )_____-_____

Are you presently employed: Y/N Name of employer_____

Employer Address_____City_____

State_____Zip code_____ Email Address_____@_____

Emergency Contact Person_____Tele#( )_____

Responsible Party:

Responsible Party- if the same as above check box ☐. If different please fill out information below

Name of Person responsible (Last, First, MI)_____

Relationship to patient_____ DOB(mm/dd/yyyy)_____ SS#_____-_____-_____

Drivers License#_____ Occupation_____ Age_____

Address_____City_____

State_____Zip code_____ Sex_____ Marital Status: S / M / D / Sep / Widow / Civil Union / Other

Home Tele#:( )_____-_____Cell# ( )_____-_____Work#( )_____-_____

Are you presently employed: Y/N Name of employer_____

Employer Address_____City_____

State_____Zip code_____

Insurance Information: (If a photocopy of both the front and back of your insurance card cannot be furnished please fill in your insurance information below). HMO patients please furnish your authorization approval

Primary Insurance Carrier Name_____HMO/PPO/Other

Policy/Medicare Number_____exp date___/____/20____

Do you have a secondary or additional Insurance Y/N

Financial Agreement:

Payment is due at the time of service. We accept cash, debit and credit cards. I the undersigned, have insurance as listed above and directly assign to Lewit Worrell, MD Inc all medical and surgical benefits and payments, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all (medical/surgical) information necessary to secure the payment of benefits, I authorize the use of this signature on all insurance submissions. I fully understand this agreement and consent will continue until cancelled by me in writing. I read and understand English.

Signed_____Date_____/_____/20____

Authorization for Medical, Surgical treatment, Media recording:

I, the undersigned, do hereby consent to medical and surgical care and treatment necessary to formulate a diagnosis and treat me and give reasonable and proper medical care by today's community standards. This may include but is not limited to physical exams, xrays, local anesthesia, still and video photography and any other entity that the doctor thinks in his best judgment is needed to give the best care needed . This care will be given by Dr Lewit Worrell, MD, the employees of Foothill ENT Care Specialists and it's associates. This consent will continue until cancelled by me in writing. I fully understand this agreement, I read and understand English

Signed_____Date_____/_____/20____

Referral Source (check one): ☐ Internet ☐ Dr.:_____ ☐ Telephone Book

☐Other Patient/Relative Mr/s:_____

Confidentiality Agreement

The HIPPA privacy rules gives patients the right to request restrictions on usage and disclosures of their protected health information.

I, the undersigned give permission to Foothill ENT Care Specialists its employees and associates to share any and all aspects of my medical records with the following people:

Name	Relationship

In the event that you need to be contacted please check one of the following:

☐ I wish to be contacted
- At home
- By phone, ok to leave message. Telephone:_____

☐ I wish to be contacted
- At Work: Telephone:_____

☐ I wish to be contacted
- By cellphone
- Ok to leave message: Telephone:_____

☐ Other_____

Patients Name (Print):_____

Signature: _____ Date:_____

Notice of Privacy Practices Acknowledgement

Foothill ENT Care Specialists
1334 W Covina Blvd, Ste 101
San Dimas, CA 91773

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among any healthcare providers who may be involved in my treatment directly and indirectly.
2. Obtain payment from third-party payers for you.
3. Conduct normal healthcare operations such as quality assessments.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.
I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address above to obtain a current copy of the Notice of Private Practices.
I understand that I may request in writing to you that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:
_____
Relationship to Patient:
_____
Signature:
_____
Date:
_____/_____/20____

Office Use Only
I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Date_____Initials_____Reason_____
_____

Review of System / PFSH Questionnaire

Lewit Worrell MD

PATIENT NAME: **PHYSICIAN:**

Last Seen Physician: _____, _____

Last Visit Date:

Medical Group: **Phone #:**

Address:

City: **St:** **Zip:** **E-Mail:**

CATEGORIES	YES	NO
Do you have or have you ever had:		
GENERAL HEALTH:		
Describe your general health: _____		
List ALL your medical problems/conditions _____		
Any personal or religious restrictions: _____		
Have you ever had any unexplained weight gain or loss?	☐	☐
Have you ever been diagnosed and treated for cancer?	☐	☐
Have you ever had any radiation treatments?	☐	☐
Do you have a loss of appetite?	☐	☐
Do you experience night sweats and/or recurring fevers?	☐	☐
Do you have or have you ever had:		
HEAD AND NECK:		
Recurrent headaches	☐	☐
Prescription glasses or contacts	☐	☐
Glaucoma	☐	☐
Ear pain	☐	☐
Hearing problems	☐	☐
Nasal discharge	☐	☐
Persistent sore throat	☐	☐
Swollen neck glands	☐	☐
Recurrent neck ache or pain	☐	☐
Injury to the head, neck, jaw, teeth	☐	☐
Do you have or have you ever had:		
CARDIOVASCULAR:		
High blood pressure	☐	☐
Pacemaker	☐	☐
Swollen ankles	☐	☐
Irregular or rapid heart beats	☐	☐
Chest pain due to physical exertion or upset	☐	☐
Rheumatic fever or heart disease	☐	☐
Heart murmur/congenital heart disease	☐	☐
Mitral valve prolapsed	☐	☐
Heart attack and/or angina	☐	☐
Other heart problem	☐	☐
Stroke	☐	☐
Do you have or have you ever had:		
GASTROINTESTINAL/GENITO-URINARY:		
Difficulty swallowing	☐	☐

Review of System / PFSH Questionnaire

Lewit Worrell MD

PATIENT NAME: **PHYSICIAN:**

CATEGORIES	YES	NO
Acid reflux while eating certain foods	☐	☐
Persistent diarrhea/odd colored stools	☐	☐
Unexplained vomiting/frequent nausea	☐	☐
Hepatitis or other liver disease	☐	☐
Jaundice	☐	☐
Awaken more than twice a night to urinate	☐	☐
Kidney disease/renal dialysis	☐	☐
Any urinary infections	☐	☐
Sexually transmitted diseases: STD	☐	☐
Rectal bleeding	☐	☐
Sexual difficulty	☐	☐
Male- Testicular pain	☐	☐

Do you have or have you ever had:

NEUROMUSCULAR SYSTEM:

Fainting spells or loss of consciousness	☐	☐
Seizures	☐	☐
Numbness, tingling, or paralysis	☐	☐
Multiple sclerosis/muscle weakness	☐	☐
Recurrent backaches	☐	☐
Dizziness, loss of balance, problem walking	☐	☐
Persistent stiffness or painful joints	☐	☐

Do you have or have you ever had:

HEMA/ENDO/IMMUNE:

Bruise easily or excessively after a cut or trauma	☐	☐
A blood transfusion	☐	☐
Anemia	☐	☐
Diabetes	☐	☐
Thyroid or adrenal gland disease	☐	☐
AIDS	☐	☐
Positive blood test for HIV antibodies	☐	☐

Do you have or have you ever had:

RESPIRATORY:

Breathing problems	☐	☐
Asthma or emphysema	☐	☐
Tuberculosis	☐	☐
Persistent cough	☐	☐
Coughed up blood	☐	☐
Pneumonia	☐	☐
Loud snoring	☐	☐
Someone tell you your breathing has stopped during sleep	☐	☐
Episodes of waking up during the night gasping for air	☐	☐
Episodes of falling asleep while driving	☐	☐
Excessive sleepiness during the day	☐	☐
Waking up in the morning with a headache	☐	☐
Kicking or jerking of your legs while asleep	☐	☐
Trouble breathing while asleep	☐	☐

Do you have or have you ever had:

DENTAL:

Review of System / PFSH Questionnaire

Lewit Worrell MD

PATIENT NAME: **PHYSICIAN:**

CATEGORIES	YES	NO
Chronic face pain/jaw pain	☐	☐
Clicking/popping jaw	☐	☐
Difficulty opening or closing jaw	☐	☐
Episodes of grinding/clenching your teeth	☐	☐
To take antibiotics before dental procedures?	☐	☐

ALLERGIES:

Med/Agent	Reaction	Status	React. Date

Do you have or has your family ever had:

FAMILY HISTORY:

Bleeding disorder	☐	☐
Heart disease	☐	☐
Cancer:	☐	☐
Diabetes	☐	☐
Mental/emotional disorders	☐	☐
Other Illnesses that run in the Family	☐	☐

Any genetic disease/illnesses:

_____

Do you have or have you ever had:

SOCIAL HISTORY:

Occupation

_____

Smoking Status:	☐	☐
Smoked?	☐	☐
Used alcohol?	☐	☐
Used recreational drugs?	☐	☐
Used Intravenous recreational drugs?	☐	☐
Engaged in high risk sexual behavior?	☐	☐
Any recent travel out of the country	☐	☐

Do you have or have you ever had:

WOMEN ONLY:

Do you menstruate regularly?	☐	☐
Do you flow heavily?	☐	☐
Vaginal discharge	☐	☐
Sexual difficulty	☐	☐
Are you pregnant?	☐	☐
Are you presently breast feeding	☐	☐
Are you in or have you passed through menopause?	☐	☐

Number of pregnancies

_____

Number of miscarriages

Review of System / PFSH Questionnaire

Lewit Worrell MD

PATIENT NAME: **PHYSICIAN:**

CATEGORIES	YES	NO

Do you have or have you ever had:

GENETIC SCREENING:

Review of System / PFSH Questionnaire

PATIENT NAME: **PHYSICIAN:**

CATEGORIES

List all prescription and non-prescription drugs (including aspirin) taken within the past 6 months- Including name and dosage

Medication	Strength	Form	Instruction	Start Date

List all hospitalizations and surgeries

Date	Reason

Medical Authorization

Lewit Worrell MD

PATIENT NAME: **PHYSICIAN:**

CATEGORIES

Notice of Privacy

I here by acknowledge that I have received the *Notice of Privacy Practices* from Foothill ENT Care Specialists. I have been provided an opportunity to read and review it. I understand I an entitled to receive a paper copy of the *Notice of Privacy Practices* at any time. I understand that, unless I object, Foothill ENT Care Specialists may disclose my Protected Head Information to a family member, personal representative, or close personal friend or somebody else who I have listed elsewhere is my medical files as may be necessary in order to involve the recipient of the information in my care, or in order to obtain payment for my care, or in order to notify such persons of my location, general condition, or death.

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

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Signature of Patient or Parent/Legal Guardian if Minor **Date**